

U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 09 June 2006

CASE NO.: 2004-BLA-5949

In the Matter of:

EDGAR J. HUGGINS,
Claimant

v.

WINDSOR COAL CO.,
Employer

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest

Appearances

Robert F. Cohen, Jr., Esq.
For the Claimant

William S. Mattingly, Esq.
For the Employer

Before: MICHAEL P. LESNIAK
Administrative Law Judge

DECISION AND ORDER – AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq.* (Act). The Act and implementing regulations, 20 C.F.R. Parts 410, 718, and 725 (Regulations), provide compensation and other benefits to coal miners who are totally disabled by pneumoconiosis and to the surviving dependents of coal miners whose death was due to pneumoconiosis.

The Act and Regulations define pneumoconiosis (commonly known as black lung disease, coal workers' pneumoconiosis or CWP) as a chronic dust disease of the lungs and its

sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. 20 C.F.R. § 725.101.¹

The findings of fact and conclusions of law that follow are based upon my thorough analysis and review of the entire record, arguments of the parties, and applicable statutes, regulations, and case law. Each exhibit entered in evidence, although possibly not mentioned in this Decision, has been carefully reviewed and considered in light of its relevance to the resolution of a contested issue. The resolution of black lung benefit claims frequently requires the evaluation and comparison of conflicting evidence. Where evidence may appear to conflict with the conclusions in this case, the appraisal of the relative merits and evidentiary weight of all such evidence was conducted strictly in accordance with the quality standards and review procedures set forth in the Act, Regulations, and applicable case law.

PROCEDURAL HISTORY

Claimant filed his first claim for benefits with the Department of Labor (DOL) on March 29, 1994. (DX-1). The District Director issued a Proposed Decision and Order on August 30, 1994, in which he denied the claim, finding that Claimant was unable to establish any element of entitlement. (DX-1).

On July 17, 2002, Claimant filed this claim for benefits, his second, with the DOL. (DX-3). The District Director issued a Proposed Decision and Order on November 18, 2003, in which he denied the claim, finding that the evidence did not support a totally disabling respiratory impairment. (DX-26). Claimant objected to the findings of the District Director by stating that he wished to appeal the decision and request a hearing. (DX-29). This matter was transferred to the Office of Administrative Law Judges on March 10, 2004. (DX-35).

I held a formal hearing in this case on January 11, 2005 in Morgantown, West Virginia. At the hearing, I afforded all parties a full opportunity to present evidence and argument, as provided in the Act and Regulations. At the hearing, I admitted Director's Exhibits 1-38, Employer's Exhibits 1-12, and Claimant's Exhibits 1-5.² (TR-5, 36, 30, 139). On April 7, 2005, Claimant submitted a deposition of Dr. Green, which I hereby admit as Claimant's Exhibit 7.

The parties stipulated that the present application was filed on July 17, 2002, that this is a subsequent application filed more than one year after the prior denial of benefits, that Claimant was a coal miner for at least 33 years, that Claimant's wife Zeta is a dependent, and that Windsor Coal Company is properly named as the responsible operator. (TR-36-38).

¹ The following abbreviations are used in this opinion: DX = Director's exhibit, EX = Employer's/Carrier's exhibit, CX = Claimant's exhibit, TR = Transcript of the January 11, 2005 hearing, BCR = Board-certified radiologist, B = NIOSH-certified B-reader.

² At the hearing, I did not formally admit Claimant's Exhibit 5. However, it is clear that Claimant's Exhibit 5 was intended to be offered and admitted at hearing and that all parties acted as if Claimant's Exhibit 5 were admitted. Thus, for the sake of procedural clarity, I formally admit Claimant's Exhibit 5 now. Furthermore, Claimant's Exhibit 6 was objected to by opposing counsel and not admitted into the record.

Employer's closing brief was received in this office on February 17, 2006. Claimant's closing brief was received on March 31, 2006.

ISSUES

- 1) Whether the evidence establishes a material change in condition of entitlement pursuant to § 725.309;
- 2) Whether Claimant has pneumoconiosis;
- 3) Whether Claimant's pneumoconiosis arose out of his coal mine employment;
- 4) Whether Claimant is totally disabled; and
- 5) Whether Claimant's total disability is due to pneumoconiosis.

(DX-35; TR-38).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Preliminary Ruling

Subsequent Claim

In this case, where the miner filed more than one claim and the earlier claim was denied, the later claim must also be denied on the grounds of the earlier denial unless the evidence demonstrates that one of the applicable conditions of entitlement has changed since the date upon which the order denying the prior claim became final. 20 C.F.R. § 725.309(d).

In the Decision and Order denying benefits, dated August 30, 1994, the District Director denied the claim based upon his findings that Claimant was unable to establish any element of entitlement. (DX 1). As outlined below, the weight of the newly submitted evidence, namely the biopsy evidence, establishes that Claimant has developed clinical pneumoconiosis since the final denial of the prior claim. Accordingly, I find that Claimant has established a change in at least one of the applicable conditions of entitlement under § 725.309(d)(3).

Medical Evidence

Chest X-rays

Exhibit	X-ray Date	Physician/Qualifications	Interpretation
DX-1	6/30/94	Jaworski, B	Quality 1, s, t opacities in lower four zones, profusion 0/1
DX-1	6/30/94	Harron, BCR/B	Quality 1 – quality reading only
DX-17	8/29/02	Devabhaktuni	Quality 1 - No parenchymal abnormalities consistent with pneumoconiosis, scarring due to prior surgery
DX-18	8/29/02	Binns, BCR/B	Quality 1 – quality reading only
EX-2	1/27/04	Renn, B	Quality 1, r, q opacities in both upper zones, profusion 0/1.
CX-1	10/8/04	Tallaksen	Pulmonary nodules present bilaterally and appear stable, including largest one at right base now visible in the costophrenic angle. Pleural fluid on left resolved.

Several x-rays were taken at the Monongalia General Hospital. These x-rays are dated 3/3/84; 7/29/86; 12/25/88; 2/23/93; and 2/14/02. These x-rays were not taken for the purposes of establishing the existence or non-existence of pneumoconiosis. Findings included patchy area of density in left costophrenic angle believed to represent acute inflammatory infiltrate; right lung appears clear; suggestion of several small nodular densities located peripherally to vague density in left costophrenic angle; vague density in left costophrenic angle and suggestion of several small nodular densities located peripherally just above density; chronic parenchymal density at left base unchanged; normal expansion without pneumothorax or infiltrate; no interstitial edema and vascularity appears within normal limits; status post biopsy; and numerous bilateral pulmonary nodules some of which are clearly pleural based. (EX-6).

Many x-rays were taken at West Virginia University after Claimant underwent a thoracoscopy and Chamberlain procedure. X-rays are dated 10/4/02; 2/14/03; 2/15/03 (two); 2/16/03; 2/17/03; 2/21/03 (two); 3/28/03; and 2/1/04. These x-rays were taken for purposes of assessing Claimant's post-surgical condition and not for purposes of establishing the existence or non-existence of pneumoconiosis. Findings on these x-rays included post-surgical changes with atelectasis; patchy opacities in the right lung base likely reflecting resolving post surgical changes; redemonstration of cardiomegaly; central vascular congestion; left pleural effusion; elevation of left hemidiaphragm; redemonstration of nodular density in right mid lung projecting over 4th rib, corresponds to nodular density seen on CT chest of 1/24/03; several nodular-appearing densities located within the right upper lung zone; interstitial and central vascular markings are slightly prominent; and nodules visible in both apices and below right diaphragm, corresponds to appearance on CT scan of 2/25/03. (EX-5)

Pulmonary Function Studies

Exhibit	Date	Height ³ / Age	FEV ₁	FVC	MVV	FEV ₁ /FVC	Coop/ Comp	Qualifying?
EX-6	8/8/86	69” 48	3.45 3.26*	4.55 4.21*	69 42*	76% 77%*	Fair Good	No No
EX-6	9/9/88	69” 50	3.42 3.75*	4.73 4.88*	114 132*	73% 76%*	Good Good	No No
DX-1	6/30/94	69” 56	2.46 1.83*	3.88 3.51*	62 72*	63% 52%*	Good Good	No Yes
DX-14	8/29/02	69.5” 64	1.94 1.60*	2.78 2.71*	--- ---	70% 59%*	Poor Fair	No No
CX-1 (EX-5)	3/7/03	176 cm (69.29”) 64	1.46 1.60*	2.10 2.17*	--- ---	70% 74%*	ATS criteria not met	Yes Yes
DX-15 ⁴	6/6/03	69.5” 64	1.50 1.47*	2.25 2.35*	--- ---	67% 63%*	Fair Fair	Yes Yes
CX-1 (EX-5)	11/3/03	177 cm (69.68”) 65	1.35 1.22*	1.87 1.87*	--- ---	71.8% 65.3%*	ATS criteria not met	Yes Yes
EX-2 ⁵	1/27/04	70” 65	1.74 2.04*	2.65 2.91*	45 44*	66% 70%*	Fair Fair	Yes No

* Post-bronchodilator value

Blood Gas Studies

Exhibit	Date	PCO ₂	PO ₂	Qualifying?
DX-1	6/30/94	35.7	87.4	No
DX-13	8/29/02	41 37*	83 87*	No No
EX-2	1/27/04	41	71	No

* Post-exercise result

³ The fact-finder must resolve conflicting heights of the miner recorded on the ventilator study reports in the claim. *Toler v. Easter Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995); *Protopappas v. Director, OWCP*, 6 B.L.R. 10221 (1983). As there is a variance of one inch in the recorded height of the miner, I have used 69.5” because it is the median of the recorded heights.

⁴ Dr. John. A. Michos reviewed this study and concluded that it was not a valid vent test. (DX-16).

⁵ Dr. Gregory J. Fino reviewed this test and concluded, “Valid spirometry and an invalid MVV. The invalid MVV underestimates this man’s true pulmonary function and should not be used as medical evidence of respiratory function.” (CX-4).

CT Scans

Dr. Joseph J. Renn, III

Dr. Renn interpreted two CT scans for Employer: one taken on January 29, 2002 and one taken on July 29, 2002. His interpretation of the January scan included hilar calcifications consistent with old granulomatous disease; peripheral parenchymal and pleural based nodules, some calcified, some not; a 2.5 cm right lower lobe calcified granuloma; and no opacities consistent with CWP. His interpretation of the July scan was that the changes were essentially identical to those found on the January exam. Dr. Renn concluded that the scans reveal changes consistent with old granulomatous disease but the absence of changes consistent with CWP or silicosis. (EX-1).

Monongalia General Hospital

Several CT scans were taken at Monongalia General Hospital. A July 29, 1986 scan of the chest showed an area of linear fibrosis or atelectasis identified in anterior segment of left lower lobe; bilateral posterior pleural thickening present symmetrically; a 2.7 x 2.2 lobulated subpleural mass in left lower lobe with multiple small satellite nodules adjacent; less than .5 cm subpleural nodules identified in right chest, right middle lobe, and anterior segment of left lower lobe; other small nodules are seen in left lower lobe. An addendum to this CT scan compared earlier chest x-rays for changes. The addendum notes that the density now appears denser and more coalescent; nodules on left are more apparent; slow progression suggests relatively non-aggressive process but probably represents too rapid a time course for pneumoconiosis with massive fibrosis; also is an atypical location for pulmonary massive fibrosis; could represent some granulomatous disease; and recommend continued close follow-up.

Later CT scans of January 29, 2002 and July 29, 2002 revealed multiple noncalcified densities with the largest measuring 2 cm, most likely pulmonary metastases, and multiple pulmonary nodules scattered throughout the lungs. (EX-6).

West Virginia University

A CT scan of the chest was taken at West Virginia University on January 24, 2003. Findings included multiple bilateral predominantly peripherally located pulmonary nodules, some of which are subpleural and others parenchymal. Calcified pleural plaque was noted within the bases bilaterally. A small, low attenuation lesion was seen within the right lobe of the liver. Dr. Williams' impression was nodules that could be related to chronic changes relating to Claimant's history of silicosis, but she stated that metastatic disease cannot be entirely excluded. (EX-5).

A CT scan of the chest was taken on February 24, 2003 at West Virginia University. This scan was completed after the left thoracoscopy and Chamberlain procedure. Dr. Tallaksen's impression was postoperative changes on the left including fluid collections; herniation of the lung through the chest wall surgical defect on the left; and multiple pulmonary nodules bilaterally, unchanged. (EX-5)

Another chest CT scan was taken on September 26, 2003. Dr. Williams noted the appearance of the lymph nodes. She noted nodular densities throughout the right lung that are stable. She noted that the largest nodule was in the right base, unchanged, and measuring 2.6 x 1.9. She noted several areas of parenchymal consolidation involving the left mid to lower lung zone and some persistent pleural thickening along the posterolateral aspect of the left upper and lower lung zones. She further noted that the areas of pulmonary nodularity are difficult to compare due to the partial obscurity caused from fluid. She recommended close follow-up to assess any interval change in nodules in approximately 6 months. (EX-5).

Medical Records

Monongalia General Hospital

Claimant was seen repeatedly at Monongalia General Hospital beginning in 1984. Several x-rays and CT scans were taken as noted above. A biopsy was taken and the pathology report dated August 30, 1986 reveals multiple mature appearing granulomata present; central portion of granulomata have organized dense fibrous tissue small collection of mononuclear inflammatory cell about the periphery suggest low grade ongoing inflammatory activity; multinucleated Langhan's type giant cells present; no significant crystalline material identified by polarized light microscopy; neither fungi or acid fast organisms can be seen by special stains; granulomata not that associated with sarcoidosis; and in the absence of an identifiable etiologic agent, should be considered tuberculosis. Diagnoses included granulomatous inflammation with multiple pulmonary nodules and tuberculosis suspected but not proven.

A CAT scan guided lung biopsy was taken on February 14, 2002. The biopsy revealed scar tissue with atelectatic lung and pigment laden macrophages. The final pathological diagnoses included densely hyalinized scar tissue with amorphous debris and atelectatic lung parenchyma; pigment-laden macrophages at periphery; no evidence of neoplasm; and special stains for organisms were negative.

A PET scan on March 2, 2002 showed abnormal increased metabolism posterolateral left mid lung with some thickened pleura with some irregular margins; abnormal uptake in an aorticopulmonary window lymph node; multiple hepatic areas of abnormal increased uptake consistent with metastatic disease; and no abnormal uptake in right lower lobe which may suggest granulomatous nature. Later records by Dr. Beall indicate that Dr. Gabrielle concluded that there were multiple positive areas in Claimant's liver but that the lesions in Claimant's chest were PET negative. (EX-6).

West Virginia University Hospital

On September 16, 2002, Claimant underwent right thoracoscopic resection of multiple pulmonary nodules. The purpose of the biopsy was to determine if the nodules were malignant. The pathology report from the biopsies showed multiple non-caseating granulomas with hyalinization and polarizable foreign material consistent with silicotic nodules; emphysematous

changes; focal tiny pigmented macule compatible with simple pneumoconiosis; and some anthracosis noted.

Claimant was seen by Dr. Parker as follow up for the pathology diagnoses. Dr. Parker reported that the assessment was silicosis by biopsy probably representing PMF (progressive massive fibrosis). Claimant also underwent sleep studies on September 25, 2002 and October 9, 2002. He was found to have modestly elevated Respiratory Disturbance during the entire evening with significantly elevated Respiratory Disturbance during REM sleep. He was prescribed CPAP to be used at night to assist with his sleep apnea.

On February 13, 2003, Claimant underwent left thoracoscopy and a Chamberlain procedure. A specimen of Claimant's lymph node was removed for gross analysis. The pathology report final diagnoses included: A) Level 5 Lymph Node: silicotic lymph node; B) Level 6 Lymph Node: anthrasilicosis; and C) Mediastinal fat: adipose tissue. A black nodule was seen on the surface of the part B sample. (DX-11; EX-5).

University Health Associates

Claimant had a VATS wedge resection on September 16, 2002. On October 4, 2002, Claimant had a follow up appointment for his pathological silicosis with Dr. Szwerc. Claimant complained of mild shortness of breath, particularly upon exertion which was unchanged from before surgery. Dr. Szwerc referred Claimant to Dr. Parker for further evaluation of nodules.

Claimant was seen by Dr. Parker on October 14, 2002; December 2, 2002; March 3, 2003; June 9, 2003; November 3, 2003; March 15, 2004; and September 15, 2004. Dr. Parker's progress note from September 15, 2004 lists Claimant's 200 feet dyspnea on exertion on level ground and increased breathing problems with humidity. Dr. Parker's assessment included 1) restrictive lung disease secondary to silicosis, 2) biopsy proven progressive mass and fibrosis lesion, 3) elevated left hemidiaphragm, and 4) obstructive sleep apnea. Claimant underwent pulmonary function tests on March 7, 2003 and November 3, 2003. Claimant was unable to perform up to ATS criteria.

Claimant was referred to Dr. Michelle Nuss on March 13, 2003. Her treatment notes recorded Claimant's underground mine history of 38 years. She referred to multiple nodules throughout Claimant's lungs with adenopathy and positive PET scans. Biopsy of nodules was consistent with progressive massive fibrosis with silicosis. Dr. Nuss also noted that Claimant had blood pressure problems and obstructive sleep apnea. Claimant complained of chest pain since the thoracoscopy and shortness of breath which is worse in humidity. Dr. Nuss listed Claimant's past surgical history of a left lung thoracotomy in 1986 for suspicious lung lesions which were consistent with silicosis and two recent surgeries on the right lung in 2002 and 2003. She noted all lymph nodes are consistent with noncaseating granulomas consistent with silicosis. Claimant returned for a follow up with Dr. Nuss on September 10, 2003 during which he complained of chronic shortness of breath and dyspnea on exertion. Claimant returned on February 5, 2004 with complaints of chronic shortness of breath and dyspnea. (CX-1).

Medical Reports and Testimony⁶

Dr. Andrzej Jaworski

Dr. Jaworski examined Claimant for the DOL following Claimant's initial application for black lung benefits. The examination occurred on June 30, 1994. He recorded Claimant's symptoms as dyspnea since 1980 and getting worse, cough during hot weather, occasional dull chest pain with exertion and both arms get numb associated with slight nausea and diaphoresis, occasional orthopnea, and paroxysmal nocturnal dyspnea 1 to 2 times per week. Dr. Jaworski recorded that Claimant walks around the block every evening on flat surface; that he can climb 1 flight of steps and lift up to 40 pounds but does not know how far he can carry it; and can only do two swipes with the push lawnmower before he gets short of breath. Dr. Jaworski diagnosed Claimant with mild to moderate obstructive ventilatory defect by pulmonary function testing; status post resectional lung surgery, post-operative left lung volume loss and subsegmental atelectasis and pleural thickening; and chest pain by history. Dr. Jaworski was uncertain as to the etiology of the ventilatory defect opining that it could be due to involuntary premature glottic closure during forced exhalation maneuver or other condition such as trachea/malacia. Dr. Jaworski concluded that Claimant's impairment was "probably mild and it should not prevent patient completely from performing his last CME. More precise evaluation of work capacity was not possible as the exercise testing was refused by the patient." (DX-1).

Dr. P.V. Devabhaktuni

Dr. Devabhaktuni examined Claimant for the DOL on August 29, 2002. He recorded Claimant's symptoms as thick, yellow sputum, 2-3 Tbs per day; chronic wheezing since 1983; chronic dyspnea that increases with mild exertion; chronic productive cough; hemoptysis on rare occasion; chest pain from coughing; orthopnea requiring 2-3 pillows per night; ankle edema; and paroxysmal nocturnal dyspnea waking up 4-5 times per night short of breath. Dr. Devabhaktuni recorded that Claimant never smoked. He listed Claimant's diagnoses as hypertension and chronic obstructive pulmonary disease (COPD). He noted that the COPD was questionable as Claimant's effort during tests was questionable. Dr. Devabhaktuni stated that he was unable to assess the impairment level due to Claimant's inconsistent effort on pulmonary function testing. He noted there was some pulmonary impairment due to the prior resection of the lung. (DX-12).

Dr. John E. Parker

In a letter dated August 7, 2003, Dr. Parker advised the West Virginia Workers' Compensation that he had seen Claimant in the pulmonary clinic and thoracic surgery clinic at West Virginia University. Claimant had an abnormal chest x-ray in 2002 that showed nodular densities. A PET scan and CT scan of the chest were taken. Concern about a left-sided

⁶ Medical reports and/or physicians' testimony which refer to documents not in evidence are deemed to have been redacted. Unless I make a specific finding herein that the redacted data is critical to a physician's ultimate opinion, the redaction of objectionable information will not materially affect the weight I accord such opinion. See, *Harris v. Old Ben Coal Co.*, 23 BLR 1-98, BRB No. 04-0812 BLA (Jan. 27, 2006); see also, *Webber v. Peabody Coal Co.*, 23 BLR 1-123, BRB No. 05-0335 BLA (Jan. 27, 2006)(en banc).

malignancy led to a thorocotomy and resection of the lesion. Dr. Parker advised that the resected lung tissue exceeded 5x3 cm and had anthracotic pigment and nodules consistent with silicosis. He noted that the tissue had focal pigment with macular deposition consistent with simple pneumoconiosis. Dr. Parker opined that the resected lung tissue represented progressive massive fibrosis exceeding an ILO B size lesion. Dr. Parker advised that if the lesion had not been removed, it would appear on a chest x-ray. However, removal has led to a near normal x-ray. (DX-10).

Dr. Parker provided testimony at a deposition on May 11, 2004. He reviewed the pathology reports from Claimant's various biopsy procedures. He noted the February 2003 pathology was noncaseating granulomas with birefringent foreign material, characteristic of silicates or silica. He noted that the granulomas did not suggest sarcoidosis. The lymph node pathologies were of silicotic lymph node and anthrasilicosis. Dr. Parker opined that this would be consistent with what was found in Claimant's lower lobes of his lungs. Dr. Parker discussed the pathology of the wedge resection of the lower lobe of the left lung as being typical of silica injury to the lung. Dr. Parker noted that the pathology report of the wedge resection was inconsistent with other pathology descriptions in that it did not show polarizable material consistent with silica or silicates but consistent in general description. Dr. Parker opined that he thought this was an occupational-induced injury rather than an infectious injury like tuberculosis.

Dr. Parker opined that Claimant has restriction based on spirometry and lung volumes that suggest hyperinflation. He stated that it is possible that Claimant is unable to reproduce on spirometry despite giving full cooperation. He further opined that Claimant would be impaired to perform coal mine dust work with the FEV₁ values; he stated that Claimant had moderate impairment. Dr. Parker noted that Claimant's elevated left hemidiaphragm attributes to Claimant's pulmonary function but that Claimant's pulmonary function would still be abnormal without the elevated hemidiaphragm. Dr. Parker personally reviewed some slides of Claimant's lung biopsy. He stated there was a lesion about 1.4, 1.5 cm in longest dimension. He noted that this was consistent with a PMF (progressive massive fibrosis) lesion and or large silicotic lesion. Dr. Parker opined that Claimant has silicosis and not the traditional coal workers' pneumoconiosis. He further opined that this is progressive massive fibrosis or complicated silicosis.

Dr. Parker is board-certified in internal and pulmonary medicine. Dr. Parker is chief of pulmonary and critical care at West Virginia University in the Department of Medicine, Section of Pulmonary and Critical Care Medicine, and he performs clinical work at the Medical Intensive Care Unit, the Outpatient Clinic at Ruby, and the Sleep Clinic at Ruby and HealthSouth/MountainView. (EX-11).

Dr. Joseph J. Renn, III

Dr. Renn conducted an examination of Claimant on January 27, 2004 at Employer's request. Dr. Renn listed Claimant's work history from 1956 to 1994 in underground coal mining, with periodic other jobs. Dr. Renn recorded Claimant's last employment as conveyor belt coordinator with the hardest part of the job being the walking of 6,000 feet daily in heat and

over uneven terrain and with the heaviest part being carrying his safety equipment. Dr. Renn noted that Claimant never smoked.

Dr. Renn's diagnoses at this time included:

1. Pathologic diagnosis of simple coal workers' pneumoconiosis.
2. Pathologic diagnosis of simple silicosis.
3. Pathologic diagnosis of pulmonary emphysema.
4. Probable paresis of the left hemidiaphragm.
5. Obstructive sleep apnea.
6. Mild restrictive ventilatory defect owing to [paresis of diaphragm and severe obesity].
7. Systemic hypertension.
8. Severe exogenous obesity.

(EX-2). Dr. Renn reviewed several records and reports in preparation for a supplemental report dated October 26, 2004. Dr. Renn noted that he was unable to resolve the opposing opinions of the pathologists; "[i]t appears that [Claimant] has a non-caseating granulomatous disease which Dr. Churg believes is nodular sarcoid and Dr. Zhang believes to be silicosis. Clinically, it appears that he has sarcoidosis." Dr. Renn opined that the paresis of the left hemidiaphragm would decrease Claimant's vital capacity. (EX-10).

Dr. Renn appeared at the hearing on January 11, 2005 and testified. Dr. Renn noted that paralysis of one side of the diaphragm could reduce breathing function by 25% and that Claimant appeared to have paralysis of the left diaphragm. Dr. Renn opined that a problem such as Claimant's could appear on the pulmonary function tests as a restrictive ventilatory defect and that Claimant did demonstrate a restrictive ventilatory defect on the January 2004 lung volume study and a moderate restrictive ventilatory defect on the spirometry study. Dr. Renn opined that Claimant was capable of performing his last coal mine employment because the restrictive ventilatory defect is mild. Dr. Renn further opined that Claimant being overweight considerably affected Claimant's breathing because it contributes to the restrictive ventilatory defect. Dr. Renn noted that silicotic changes in the lymph nodes does not necessarily mean that one actually has a particular disease because foreign particles that were in the lungs are picked up by the lymphatic system and dumped into the lymph nodes, which act as a "septic tank."

Dr. Renn addressed Dr. Green's report. Dr. Renn stated that he also would diagnose sarcoidosis. Dr. Renn was critical of Dr. Green's referral to the Rafnsson publication as evidence that exposure to silica in the coal mines was the cause of Claimant's sarcoidosis. Also, he noted the NIOSH study does not support Dr. Green's opinion that there is some relationship between silica dust and sarcoidosis. Dr. Renn opined that Claimant does not have a disability caused by his exposure to coal mine dust and that Claimant had sarcoidosis. (TR at 71-175).

Dr. Renn is board-certified in internal medicine, pulmonary disease, forensic medicine, and as a forensic medical examiner. Dr. Renn is a B-reader. He is an Associate Professor of Medicine at West Virginia University Medical Center and is a consultant to the Monongalia County Chest Diagnostic Clinic and to the U.S. Industrial Medicine Corp. (TR at 71; EX-3).

Dr. Francis H.Y. Green

Dr. Green evaluated slides of lung and lymph node biopsies, reviewed medical records, and prepared a report dated December 20, 2004 at Claimant's request. From the lung biopsy, Dr. Green made the following diagnoses.

1. Non-caseating granulomata with fibrosis and variable quantities of dust.
2. Simple coal worker's pneumoconiosis comprising macules and a dust nodule.

From the lymph node biopsy, Dr. Green concluded, "1. Confluent fibrotic nodules with large quantities of silica and silicates consistent with anthracosilicotic nodules."

Dr. Green opined that there was enough mining history, adequate latency, sufficient positive x-ray evidence, and sufficient biopsy evidence to conclude that Claimant has simple coal workers' pneumoconiosis. However, he opined that the pathology examination was insufficient to determine the overall severity of the pneumoconiosis. He found a nodular granulomatous fibrotic process that appears to be progressive, which is most likely due to an altered immune response to coal mine dust and silica.

Dr. Green further opined that the larger nodular and conglomerate lesions were probably best diagnosed as nodular sarcoidosis but that Claimant has not demonstrated evidence of systemic sarcoidosis and the radiologic findings are not at all typical of this disease. He referenced a series of reports that have linked sarcoidosis with pneumoconiosis. He stated, "Sarcoidosis is a disease of unknown cause and probably represents a common reaction to a variety of factors." Dr. Green concluded that Claimant has simple pneumoconiosis and a complicated form of pneumoconiosis caused by an altered immune response to silica. He opined that all of the above complicating diseases can be attributed in whole or in part to his coal mine dust exposure. (CX-2).

On March 3, 2005, Dr. Green provided testimony at a deposition. He stated that sarcoidosis is diagnosed by eliminating all other alternative diagnoses. He stated that of the five diseases he considered, as listed in the differential diagnosis⁷ section of his report, he determined that nodular sarcoidosis was the diagnosis that he favored but that he could not entirely exclude the other differential diagnoses. Dr. Green testified that although he did not diagnose silicosis, he did believe that silica played a role in contributing to the lesions. He stated that "[Claimant's] sarcoid reaction was probably being driven by the presence of silica and silicates." Dr. Green explained that sarcoid results from an abnormal suppression of the immune system; that Claimant had substantial silica exposure; that silica produces the immune suppression that can lead to sarcoidosis; and that there is an increasing body of scientific literature linking sarcoidosis to exposure to silica and other types of mineral dust. (CX-7).

Dr. Green is a board-certified in pathology, is a professor in the Department of Pathology & Laboratory Medicine at the University of Calgary, and is the head of the Autopsy Service at

⁷ The MedLine Plus medical dictionary provided by the National Library of Medicine and the National Institute of Health defines "differential diagnosis" as "the distinguishing of a disease or condition from others presenting similar symptoms." See, <http://www.nlm.nih.gov/medlineplus/plusdictionary.html> (visited June 8, 2006).

Foothills Hospital in Calgary. Dr. Green has made invited presentations and has written extensively on pulmonary diseases including black lung. (CX-3).

Dr. Andrew Churg

Dr. Churg prepared a report dated August 2, 2004 at Employer's request. Dr. Churg reviewed medical records and pathology materials in preparation for his report. Dr. Churg's analysis of the lung biopsy slides included:

[M]ultiple nodular lesions measuring up to 1.5 cm in diameter. The lesions all have central scars and around the periphery of the scars there are variable numbers of granulomas, all noncaseating. Granulomatous vasculitis is present. Away from the nodular lesions are isolated granulomas or collections of 2 or 3 granulomas, often located around bronchovascular bundles. Small amounts of pigmented, nonbirefringent, dust are seen around a few small vessels. There are no coal dust macules nor silicotic nodules.

Dr. Churg's analysis of the lymph node biopsy slides was that it showed "a single 1.5 cm nodules with surrounding granulomas similar to that described above." Dr. Churg opined that the pathologic findings were definitely not those of silicosis or coal workers' pneumoconiosis. Rather, Dr. Churg opined that the combination of noncaseating granulomas, arranged in some areas around the bronchovascular bundle, and also forming nodular lesions with central scarring was "quite typical sarcoid, and specifically the variant called nodular sarcoid."

Dr. Churg noted that sarcoid is a disease of unknown etiology. The only differential diagnosis considered was tuberculous infection. (See note 7). However, Dr. Churg noted that the mycobacterial stain of one of the specimens was reported as negative. Dr. Churg concluded that there was no evidence of pneumoconiosis of any kind in the pathology specimens but rather that there was nodular sarcoid. (EX-7). Dr. Churg is board-certified in pathology, is currently a Professor in the Department of Pathology at the University of British Columbia, and is a consultant pathologist at Vancouver Hospital. Dr. Churg has written extensively on pulmonary issues. (EX-12).

Dr. Samuel V. Spagnolo

Dr. Spagnolo prepared a report dated November 8, 2004 at Employer's request. Dr. Spagnolo thoroughly reviewed and summarized Claimant's medical history. Dr. Spagnolo noted that Claimant does not have consistent physical findings of laboratory evidence of pneumoconiosis or any chronic dust disease of the lungs caused by, significantly related to, or substantially aggravated by coal dust exposure. He stated that Claimant had classic clinical, laboratory, radiographic, and pathological evidence of sarcoidosis. Although pneumoconiosis had been diagnosed resulting in an award from the Occupational Board, Dr. Spagnolo noted that this diagnosis occurred prior to the lung biopsy.

In rendering his decision, Dr. Spagnolo placed great weight on Dr. Churg's pathological report. He noted that Dr. Churg found no silicotic nodules or coal dust macules but rather he

found non-caseating granulomas and granulomatous vasculitis, which Dr. Spagnolo noted was not a feature of pneumoconiosis. In reviewing the x-rays, Dr. Spagnolo regarded the radiographic changes described as clinically most consistent with a diagnosis of granulomatous disease either secondary to an infectious agent or caused by the medical condition known as sarcoidosis. He further noted the PET scan findings supported a diagnosis of sarcoidosis because the scan showed findings of increased metabolic activity in multiple areas of the body. Dr. Spagnolo explained that sarcoidosis often affects multiple areas and is associated with “positive” PET scans. Dr. Spagnolo concluded that Claimant had a mild restrictive disability but opined that the disability was due to the impaired function of the left diaphragm that occurred following mediastinal surgery in 2002. In Dr. Spagnolo’s opinion, Claimant had no respiratory or pulmonary impairment associated with his coal mine employment and that Claimant was not totally and permanently disabled to the extent that he would be unable to perform his regular coal mine employment. (EX-8).

Dr. Spagnolo is board-certified in internal medicine and pulmonary diseases. He currently is a Professor of Medicine at the George Washington University of Medicine, an attending physician at George Washington University Medical Center, and is the Senior Attending in Pulmonary Diseases and the Medical Director of Respiratory Care Services at Veterans Affairs Medical Center in Washington, DC. Dr. Spagnolo has published numerous articles, abstracts, and book chapters relating to pulmonary medicine. (EX-12).

Length of Coal Mine Employment

Employer has stipulated to 33 years of coal mine employment. (TR-37). I find that the record establishes an addition year of coal mine employment. (DX-6, 7). Thus, I find that Claimant was a coal miner within the meaning of the Act for at least 34 years. Moreover, any discrepancy in the exact number of years of coal mine employment is inconsequential for the purpose of rendering a decision herein.

Responsible Operator

I find and Employer has stipulated that Windsor Coal Company is properly named as the Responsible Operator. (TR-27).

Date of Filing

I find and the parties stipulate that Claimant filed this claim for benefits under the Act on July 17, 2002. (DX-3; TR-36).

Claimant’s Testimony

Claimant testified that he began working as a coal miner in 1956 and retired in 1994 because he knew that he could not do the work that would be expected of him. He stated that his wife was diagnosed with cancer in 1996. Claimant testified that as a coal miner his work was underground mining but that as a supervisor he did work above ground for a portion of the time; that he worked as a general laborer, roof bolter, shuttle car operator, miner operator, assistant

shift foreman, foreman, conveyor belt coordinator, construction supervisor, section supervisor, and mine superintendent. Claimant testified that as a roof bolter he was exposed to a lot of dust including silica dust, which he was told was silica by management. Also, as section foreman, he would take air samples while working around and being down wind of mining. Claimant's last coal mine employment was as a conveyor belt operator where he had to inspect the conveyor belt in an area no more than 5 feet high, carrying about 40 pounds of gear, and walking 6,000 feet of length. Claimant testified that he would stop around every 300 feet and go to a man door or intake escapeway to get fresh air.

Claimant testified that he never smoked. He stated that his breathing problems progressed after having quit the mines. He also stated that he tried to do his best on the pulmonary function tests but that he had trouble performing them because he could not take air in. He stated that his symptoms were worse after the third operation. He testified that he had received a 5% award for black lung in 1984 from the state of West Virginia.⁸ (TR at 38-70).

Standard of Review

The administrative law judge (ALJ) need not accept the opinion of any particular medical witness or expert, but must weigh all the evidence and draw his/her own conclusions and inferences. *Lafferty v. Cannerton Industries, Inc.*, 12 B.L.R. 1-190 (1989). The adjudicator's function is to resolve the conflicts in the medical evidence; those findings will not be disturbed on appeal if supported by substantial evidence. *Id.*

In considering the medical evidence of record, an ALJ must not selectively analyze the evidence. *See Wright v. Director, OWCP*, 7 B.L.R. 1-475 (1984); *Hess v. Clinchfield Coal Co.*, 9 B.L.R. 1067 (1986).

As the trier of fact, the ALJ has broad discretion to assess the evidence of record and determine whether a party has met its burden of proof. *Kuchwara v. Director, OWCP*, 7 B.L.R. 1-167 (1984). In considering the evidence on any particular issue, the ALJ must be cognizant of which party bears the burden of proof. Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Entitlement to Benefits

This claim must be adjudicated under the regulations at 20 C.F.R. § 718 because it was filed after March 31, 1980. Under this Section, a claimant must establish, by a preponderance of the evidence, that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that he is totally disabled due to pneumoconiosis. Failure to establish one of these elements precludes entitlement to benefits. 20 C.F.R. §§ 718.202-205; *Perry v. Director, OWCP*, 9 B.L.R. 1-1 (1986).

⁸ The state awards are not binding herein, because the statutes, regulations, and evidence which underlie them are not the same as those which apply to this Federal claim for black lung benefits.

Existence of Pneumoconiosis

The Regulations define pneumoconiosis broadly, as “a chronic disease of the lung and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment.” 20 C.F.R. § 718.201. The Regulations’ definition includes not only medical, or “clinical,” pneumoconiosis but also statutory, or “legal,” pneumoconiosis. *Id.* Clinical pneumoconiosis comprises:

[T]hose diseases recognized by the medical community as pneumoconiosis, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers’ pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis, or silicotuberculosis arising out of coal mine employment.

Id. Legal pneumoconiosis, on the other hand, includes “any chronic lung disease or impairment and its sequelae arising out of coal mine employment.” *Id.* “[A] disease ‘arising out of coal mine employment’ includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.” *Id.* Finally, the Regulations recognize that pneumoconiosis is “a latent and progressive disease” that might only become detectable after a miner’s exposure to coal dust ceases. *Id.*

The Regulations provide four methods for finding the existence of pneumoconiosis: chest x-rays, autopsy or biopsy evidence, the presumptions in §§ 718.304, 718.305, and 718.306, and medical opinions finding that Claimant has pneumoconiosis. *See* 20 C.F.R. § 718.202(a)(1)-(4). In the face of conflicting evidence, I shall weigh all of the evidence together in finding whether the miner has established that he has pneumoconiosis. *Island Creek Coal Co. v. Compton*, 211 F.3d 203, 211 (4th Cir. 2000).

Of the numerous x-rays in the record, including those taken for purposes of medical treatment, there are no x-rays that diagnosed pneumoconiosis. Although many x-rays noted opacities and nodules in the lungs, no physician reading the x-rays attributed these to pneumoconiosis. Therefore, I find that the weight of the x-ray evidence does not support a finding of pneumoconiosis.

Claimant had biopsies taken in 1986, 2002, and 2003. These procedures included a biopsy of the lung on August 30, 1986 at Monongalia General Hospital; a CAT scan guided lung biopsy on February 14, 2002 at Monongalia General Hospital; a right thoracoscopic resection on September 16, 2002 at West Virginia University Hospital; and a left thoracoscopy and Chamberlain procedure on February 13, 2003 at West Virginia University Hospital. The pathologist of the 1986 biopsy, Dr. Kahn, diagnosed granulomatous inflammation with multiple pulmonary nodules and suspected tuberculosis. He noted that the granulomata were not associated with sarcoidosis; he did not address whether pneumoconiosis was present. I credit

Dr. Kahn's opinion with little weight as the biopsy was taken approximately eight years before Claimant quit mining, and Dr. Kahn's opinion was rendered before the 2002 and 2003 biopsies were taken.

The February 14, 2002 biopsy did not address the existence of pneumoconiosis, and the February 13, 2003 biopsy was taken of two of Claimant's lymph nodes. Although the pathologist of the 2003 biopsy diagnosed silicotic lymph node, anthrasilicosis, and a black nodule on the surface of one of the samples, the biopsies of the lymph nodes were performed and not of the lungs. I find that diagnoses of the lymph nodes, by themselves, are not sufficient to determine the existence of pneumoconiosis in the lungs. However, I find this biopsy evidence lends credence to other biopsy diagnoses.

I find that the September 16, 2002 lung resection provides the best evidence of Claimant's lung condition. However, the biopsy was taken for purposes of determining malignancy and not for purposes of establishing pneumoconiosis, and thus, the original pathology report is helpful only to a degree. The pathologist who rendered the final pathologic diagnosis, Dr. Peilin Zhang,⁹ made findings of granulomas consistent with silicotic nodules, focal tiny pigmented macule compatible with simple pneumoconiosis, and some anthracosis. Two other reports were rendered by board-certified pathologists: Drs. Green¹⁰ and Churg.¹¹ I note that I do not have the credentials of Dr. Zhang other than his board-certifications, which makes it difficult to determine the weight that I should assign to his diagnoses. Drs. Green and Churg are both highly credentialed, well-respected pathologists deserving of great weight. Dr. Green opined that the lung biopsy showed simple CWP and that the larger nodular lesions could be one of several diagnoses but were probably nodular sarcoidosis. Dr. Green opined that these larger lesions were a form of complicated pneumoconiosis caused by an altered immune response to silica. Dr. Green cited medical publications to link the development of sarcoidosis to the exposure of silica. Dr. Churg concluded that the biopsy showed nodular sarcoid and that there were no coal dust macules or silicotic nodules.

I credit greater weight to Dr. Green because I find that he reviewed more pathology slides than Dr. Churg and that his report was more thorough. Furthermore, I find that Dr. Zhang's opinion and the lymph node biopsies support Dr. Green's conclusions. Thus, I find that the opinion of Dr. Green and the diagnoses by Dr. Zhang establish that Claimant suffered from simple clinical pneumoconiosis. Dr. Green opined the biopsy established a complicated form of

⁹ Dr. Zhang's credentials do not appear in the record. However, according to the American Board of Medical Specialties website, Dr. Zhang has been certified by the American Board of Pathology in anatomic pathology and clinical pathology. See, <http://www.abms.org> (visited June 8, 2006). Pursuant to 29 C.F.R. § 18.45, I hereby take official notice of Dr. Zhang's credentials.

¹⁰ Claimant identified Dr. Green's report as being a biopsy report. I find that Dr. Green's review of multiple records and opinions that go beyond the scope of rendering a pathology diagnosis, and thus Dr. Green's report should be considered a medical report. As Claimant only identified one medical report (Dr. Parker) as its affirmative evidence, I reclassify Dr. Green's report as a medical report and thus consider it for both its pathological diagnoses and its medical opinions.

¹¹ Dr. Churg's report states that he considered medical records in preparation for his report. As Employer already designated two medical reports (Dr. Renn and Dr. Spagnolo) for its affirmative case, Dr. Churg's report is only admissible as a biopsy report. Thus, it will be considered only for its pathological diagnoses.

pneumoconiosis. Dr. Zhang did not address whether the nodules were of sufficient size to be considered complicated. However, having credited greatest weight to Dr. Green, I find that Claimant has also established complicated pneumoconiosis. In conclusion, I find that the biopsy evidence does support a finding of simple clinical pneumoconiosis and complicated pneumoconiosis.

A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, based upon certain clinical data and medical and work histories and supported by a reasoned medical opinion, finds that the miner suffers from pneumoconiosis. 20 C.F.R. § 718.202(a). “Any such finding shall be based on objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.” 20 C.F.R. § 718.202(a)(4). Medical reports that are based upon and supported by patient histories, a review of symptoms, and a physical examination constitute adequately documented medical opinions as contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician’s report, although documented, fails to explain how the documentation supports its conclusions, an ALJ may find the report to be not a reasoned medical opinion. *Smith v. Eastern Associated Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion is not sufficiently reasoned if the underlying objective medical data contradicts it. *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

Several CT scans were taken between 1986 and 2003. Scans were consistently interpreted as showing multiple noncalcified and calcified densities and multiple pulmonary nodules. The 1986 scan, when compared to earlier x-rays, revealed a relatively non-aggressive process opined to be too rapid for pneumoconiosis and atypical for pulmonary massive fibrosis. Dr. Renn opined that it was old granulomatous disease and not CWP or silicosis; the 1986 scan was opined to show granulomatous disease; and Dr. Williams opined of the January 2003 scan that the nodules could be related to Claimant’s history of silicosis. As most CT scan interpretations did not address whether pneumoconiosis was present, I find that the CT scan evidence is not particularly useful in assessing the presence of pneumoconiosis. However, Dr. Renn did interpret the January and July 2002 CT scans for the purpose of assessing the presence of pneumoconiosis and concluded the changes were consistent with old granulomatous disease. His opinion is supported by statements in the other interpretations. Thus, I find that the Claimant has not established pneumoconiosis by the CT scan evidence.

Regarding the medical reports prepared for this matter, I initially credit little weight to the opinions of Dr. Jaworski and Dr. Devabhaktuni. Dr. Jaworski’s evaluation of Claimant is now twelve years old and not the best evidence of Claimant’s current condition. Dr. Devabhaktuni’s report did not address the biopsy evidence that existed at the time and was also written prior to the September 16, 2002 resection. I find Dr. Devabhaktuni’s report to be not as complete or as thorough as other reports.

Drs. Parker, Spagnolo, and Renn are all board-certified in internal medicine and pulmonary diseases, and Dr. Renn has additional certifications in forensic medicine and as a forensic medical examiner. I find their reports and Dr. Parker’s testimony to be thorough and

well-reasoned for the most part. As noted before, I also consider Dr. Green's medical report, which is also thorough and well-reasoned

However, I credit the most weight to the opinion of Dr. Parker. As Claimant's treating pulmonologist, his opinion must, therefore, be considered pursuant to § 718.104(d). This regulation states that the relationship between the treating physician and the miner may constitute "substantial evidence" towards assigning controlling weight to a treating physician's opinion, provided it is credible "in light of its reasoning and documentation, other relevant evidence and the record as a whole." § 718.104(d)(5). The regulations list several factors to be considered including the nature of the relationship, the duration of the relationship, the frequency of the treatment, and the extent of the treatment. 20 C.F.R. § 718.104(d). Dr. Parker's records do establish he treated the miner every couple of months from 2002 through at least 2004. Claimant was referred to Dr. Parker following the September 2002 lung biopsy. Dr. Parker had a thorough understanding of Claimant's past medical history and had even reviewed some of the pathology slides prior to providing his deposition testimony.

I find Dr. Parker's opinion to be credible and well-based on the medical evidence of record. Furthermore, Dr. Parker has extensive experience working with and researching occupational lung diseases and has spent considerable time working at NIOSH. Dr. Parker opined the biopsies were consistent with PMF, the noncaseating granulomas with birefringent material were characteristic of silicates or silica, and the granulomas did not suggest sarcoidosis. He opined that the resected lung tissue did represent PMF which exceeded the ILO B size lesion allowing for a diagnosis of complicated pneumoconiosis. Dr. Parker concluded that this was typical of a silica injury and that it was occupationally-induced rather than an infectious injury.

Dr. Green wrote his opinion using a differential diagnosis of the larger nodular and conglomerate lesions in which he laid forth in a very thorough manner all the potential diagnoses for the large nodules. (See note 7). He explains, for each potential diagnosis, which medical evidence does and does not support the diagnosis. Ultimately, he concluded that sarcoidosis was his preferred diagnosis but that he could not conclusively exclude the other diagnoses. Nevertheless, Dr. Green did opine that all the differential diagnoses were caused from the same source: silica. (See note 7). Dr. Green acknowledged that there is no known single cause of sarcoidosis. However, he did opine that silica can cause an immune deficiency. He further opined that, based on publications and studies, there is a growing opinion that silica may be a cause of sarcoidosis. In particular, he cited a study by Raffnson *et al.* which found an increased rate of sarcoidosis with exposure to crystalline silica. Dr. Green also cited in his report and discussed in his deposition several other publications that addressed the association between exposure to silica and the risk of sarcoidosis. Nevertheless, his opinion also included a diagnosis of simple pneumoconiosis and opined that the large lesions were a form of complicated pneumoconiosis.

The opinions of Dr. Parker and Dr. Green are opposed by the opinions of Dr. Spagnolo and Dr. Renn. I assign less weight to Dr. Spagnolo's report because I find that his opinion relied greatly on Dr. Churg's pathology report and I found Dr. Green's pathology opinion, supported by Dr. Zhang's, to outweigh Dr. Churg's opinion. Thus, I find that Dr. Spagnolo's conclusions

finding no evidence of pneumoconiosis are not consistent with the weight of the medical evidence and in particular the biopsy evidence.

Dr. Renn provided an extensive review of Claimant's medical records and a thorough review of the reporting physicians. However, I also find that Dr. Renn's opinion is inconsistent with the weight of the evidence. In particular, I note that Dr. Renn initially included a pathologic diagnosis of simple CWP and simple silicosis. Later, upon reviewing Dr. Zhang's and Dr. Churg's opinion, Dr. Renn stated that he could not resolve the opposing opinions of the pathologists. Ultimately, and upon reviewing Dr. Green's report, Dr. Renn concluded, "Clinically, it appears he has sarcoidosis." Dr. Renn never reviewed the actual pathology slides. However, he diagnosed sarcoidosis from Dr. Green's and Dr. Churg's reports while disregarding the clinical pneumoconiosis diagnoses from Dr. Zhang's and Dr. Green's reports. He stated that he agreed with Dr. Green that there was no evidence of PMF, complicated CWP, or silicosis, but Dr. Green noted in his deposition that Dr. Renn overstated his opinion because although he noted that sarcoidosis was the most probable diagnosis he could not and did not entirely exclude the other differential diagnoses. (See note 7). Furthermore, Dr. Green opined that Claimant had simple pneumoconiosis and a complicated form of pneumoconiosis caused by an altered immune response to silica, which Dr. Renn did not include in his conclusions. I find that Dr. Renn has not provided sufficient reasoning in his opinion to explain why he excluded the diagnosis of simple pneumoconiosis despite the weight of the evidence, particularly when he included this diagnosis in his original opinion.

Thus, I am left with three diagnoses of sarcoidosis: Drs. Green, Spagnolo, and Renn; two diagnoses of simple pneumoconiosis: Drs. Green and Parker; and two diagnoses of a complicated form of pneumoconiosis: Drs. Green and Parker. While three opined that Claimant had sarcoidosis, only Dr. Green attributed it to his coal mine dust exposure. Drs. Spagnolo and Renn concluded that there is no known cause of sarcoidosis, and Dr. Renn questioned the publications on which Dr. Green relied. I have assigned the greatest weight of the medical opinions to Dr. Parker as Claimant's treating physician. Furthermore, I assigned great weight to Dr. Green based on his pathological diagnoses of the biopsies. Finding that Dr. Spagnolo's report relied Dr. Churg's pathology, which I found was outweighed by Dr. Green's pathology, and finding Dr. Renn's report to be inconsistent with the weight of the medical evidence, I find that the opinions of Drs. Parker and Green outweigh the opinions of Drs. Spagnolo and Renn. Thus, I find that Claimant has established by a preponderance of the evidence that he suffers from a simple form of pneumoconiosis.

More difficult to assess is whether the evidence has established a form of complicated pneumoconiosis. While I credited the most weight overall to Dr. Parker's opinion, I also found that Dr. Green's certification as a pathologist entitled him to be given great weight in assessing the pathology. I find that Dr. Green's opinion, while concluding a likely diagnosis of sarcoidosis which is contrary to Dr. Parker's findings, did not conclude an ultimate finding of sarcoidosis. While Dr. Green's opinion is not particularly helpful in identifying the type of large lesions, as the opinion included several differential diagnoses, Dr. Green did conclude that all possible differential diagnoses were caused by silica. (See note 7). This is consistent with Dr. Parker's conclusion that the large lesions were an occupationally-induced injury consistent with silica. Based on the legal definition of pneumoconiosis provided above and the requirements of §

718.304, I find that the opinions of Drs. Parker and Green establish that Claimant also suffers from complicated pneumoconiosis.

Pursuant to the holding in *Island Creek Coal Co.*, I must weigh all of the evidence under 20 C.F.R. § 718.202(a) together in determining whether Claimant has established pneumoconiosis. I find that Claimant has not established the existence of pneumoconiosis through the radiological evidence. I find that Claimant has established the existence of both simple and complicated pneumoconiosis through the biopsy evidence. I find that the CT scan evidence does not support a finding of pneumoconiosis. Finally, I find the medical reports do support a finding of both simple and complicated pneumoconiosis. I find that the great weight of the evidence does support a finding that Claimant has pneumoconiosis, both in simple and complicated form.

Therefore, after weighing all of the evidence together, I find that Claimant has met his burden of establishing the existence of pneumoconiosis.

Cause of Pneumoconiosis

Once it is determined that the miner suffers from pneumoconiosis, it must be determined whether the disease arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in the coal mines, then there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). Claimant was employed in the coal mines for 34 years, thus he is entitled to the rebuttable presumption that his pneumoconiosis arose out of coal mine employment. I find that Employer has not presented sufficient evidence to rebut the presumption that the pneumoconiosis arose out of coal mine employment.

Evidence of Total Disability

A miner shall be considered totally disabled if the irrebutable presumption in § 718.304 applies. If that presumption does not apply, then a miner shall be considered totally disabled if his pulmonary or respiratory impairment, standing alone, prevents him from performing his usual coal mine work and comparable and gainful work. 20 C.F.R. § 718.204(b)(1). In the absence of contrary probative evidence, a miner's total disability shall be established by pulmonary function studies showing the values equal to or less than those in Appendix B, blood gas studies showing the values in Appendix C, the existence of cor pulmonale with right-sided congestive heart failure, or the reasoned and documented opinion of a physician finding that the miner's pulmonary or respiratory impairment prevents him from engaging in his usual coal mine work and comparable and gainful work. 20 C.F.R. § 718.204(b)(2).

Claimant is eligible for the irrebutable presumption in § 718.304 that he is totally disabled by pneumoconiosis because he has established by a preponderance of the evidence that he has complicated pneumoconiosis. However, even if Claimant did not have complicated pneumoconiosis, I find that Claimant has established that he is totally disabled as a result of his simple pneumoconiosis.

The record includes pulmonary function studies and blood gas studies. The blood gas studies did not produce any qualifying results. The pulmonary function studies were performed in 1986; 1988; 1994; 2002; 2003; and 2004. The tests produced four qualifying test results between 2003 and 2004. Recognizing pneumoconiosis to be progressive and latent, I place greater weight on the more recent pulmonary function tests. However, physicians have invalidated the results of two of these tests and the ATS criteria was not met for two of the other tests.

Several physicians have rendered opinions regarding Claimant's level of disability. Dr. Jaworski opined that Claimant's impairment was "probably mild." However, as stated above, Dr. Jaworski's evaluation of Claimant occurred in 1994 and is not the best evidence of Claimant's current impairment. Dr. Devabhaktuni stated that he was unable to assess Claimant's impairment level due to inconsistent effort on pulmonary function testing but noted that was some impairment due to the resection of the lung.

Drs. Parker, Renn, and Spagnolo also rendered opinions on Claimant's pulmonary impairment. Dr. Renn opined that Claimant was capable of performing his last coal mine employment because the restrictive ventilatory defect was mild. Dr. Spagnolo opined that Claimant was not totally and permanently disabled to the extent that he would be unable to perform his regular coal mine employment. Dr. Parker addressed Claimant's pulmonary function test inconsistencies as Claimant's inability to reproduce on spirometry, which according to Dr. Parker has been correlated to premature death. However, Dr. Parker did conclude that Claimant's impairment rendered him unable to perform his coal mine employment.

Taking into consideration Claimant's testimony regarding his last coal mine employment, the description of the physical nature of his job, and his statements regarding the pulmonary function tests, I find Claimant's testimony to be credible. I find that Dr. Parker's analysis of the pulmonary function tests further supports a finding of moderate impairment. Coupling a moderate impairment with the very labor intensive work that Claimant was to perform, I find there is sufficient evidence establishing that Claimant is totally disabled from performing his last coal mine employment.

Causation of Total Disability

A miner shall be considered totally disabled due to pneumoconiosis if pneumoconiosis is a substantially contributing cause of his totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's total disability if it has a material adverse effect on his respiratory or pulmonary impairment or it materially worsens a totally disabling respiratory or pulmonary impairment caused by a disease or exposure unrelated to coal mine employment. 20 C.F.R. § 718.204(c)(1).

Both Drs. Parker and Renn noted that Claimant's paralyzed left hemidiaphragm, the result of a phrenic nerve injury during the 2002 biopsy, could result in an impairment of 10-15% and 25%, respectively. However, Dr. Parker opined that Claimant's pulmonary function would still be abnormal even if not for the paralyzed left hemidiaphragm. When asked whether Claimant could have performed his last coal mine employment if he had not had the phrenic

nerve injury, Dr. Parker responded, "Perhaps." Nevertheless, Dr. Parker noted that Claimant would not have had the phrenic nerve injury if he had a normal chest x-ray; Claimant would not have had an operation.

As discussed above in my findings of pneumoconiosis, I find that Drs. Parker and Green establish that Claimant's coal mine dust exposure contributed to the large lesions in Claimant's lungs. I also find that Claimant's exposure to silica while working in the coal mines contributed to the images apparent on the x-rays and CT scans. I find that there is sufficient evidence to attribute the abnormal x-ray results to Claimant's silica exposure. Additionally, I find that but for Claimant's abnormal chest x-ray Claimant would not have suffered the phrenic nerve injury. Thus, Claimant's phrenic nerve injury and resulting impairment is an indirect result of Claimant's coal mine dust exposure.

Furthermore, I find there is sufficient evidence establishing a mild respiratory impairment unrelated to the phrenic nerve injury. Therefore, even if the impairment attributed to the phrenic nerve were not related to Claimant's coal mine dust exposure, I find that the pulmonary impairment that is directly attributed to coal mine dust exposure materially worsened the phrenic nerve impairment and renders Claimant totally disabled from coal mine employment. Weighing all of the physician opinion evidence, I find that the preponderance of the evidence establishes that pneumoconiosis is a substantially contributing cause of Claimant's total disability.

CONCLUSION

Because Claimant has established all elements of entitlement, I conclude that he has established entitlement to benefits under the Act.

Date of Onset

In a case where the evidence does not establish the month of onset of total disability due to pneumoconiosis, benefits are payable beginning with the first day of the month during which the claim was filed. In the instant matter, Claimant filed his claim on July 17, 2002. (DX-3).

Attorney's Fee

No award of attorney's fees for services to the Claimant is made herein, as no application has been received. Thirty days are hereby allowed to Claimant's counsel for the submission of such application; his attention is directed to 20 C.F.R. §§ 725.365 and 725.366. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. Parties have ten days following receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim of Edgar Huggins for Black Lung benefits under the Act is hereby GRANTED, and

It is hereby ORDERED that Windsor Coal Company, the Responsible Operator, shall pay to the Claimant, Edgar Huggins, all augmented benefits to which he is entitled under the Act, commencing July 2002.

A

MICHAEL P. LESNIAK

Administrative Law Judge

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Avenue, NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).